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GUYANA HIV/AIDS ASSESSMENT

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CONTENTS

TABLES AND FIGURES

ACRONYMS

AB	Abstinence and being faithful
ANC	Antenatal care
ARV	Antiretroviral
BSS	Behavioral surveillance surveys
CARICOM	Caribbean Community
CDC	U.S. Centers for Disease Control and Prevention
CSDS	Community Support and Development Service
CSIH	Canadian Society for International Health
DHS	Demographic and Health Survey
GFATM	Global Fund to fight AIDS, TB, and Malaria
HIPC	Heavily-Indebted Poor Countries
HIS	Health information system
ILO	International Labour Organization
IPED	Institute for Private Enterprise Development
M&E	Monitoring and evaluation
MIS	Management information system
MMU	Materials Management Unit
MOH	Ministry of Health
NAPS	National AIDS Program Secretariat
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
SCMS	Supply Chain Management System
STI	Sexually transmitted infection
TB	Tuberculosis
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDOL	U.S. Department of Labor
USG	U.S. Government
VCT	Voluntary counseling and testing
WHO	World Health Organization

I. INTRODUCTION

In 2004, the United States Agency for International Development (USAID)/Guyana Mission began implementation of strategic plans that covered the period from 2004–2008. As such, the Mission will soon begin implementation of the final year of this strategic plan. In an effort to garner the success of program interventions to date and gather data that will serve as the basis for the development of future implementation plans, the USAID/Guyana Mission implemented an assessment of its HIV/AIDS portfolio and work under the President's Emergency Plan for AIDS Relief (PEPFAR) to date.

GOALS AND OBJECTIVES

The primary objective was to assess the USAID/Guyana HIV program under the 2004–2008 strategy to examine programmatic successes and weaknesses. Specifically the team assessed progress in the areas of indicators, cost-efficient partners and approaches, possible best practices, and remaining gaps in programming. This assessment was used to determine where better approaches could have been used and to make suggestions for future program interventions. The findings of this assessment serve as a foundation for the development of the conceptual framework and assistance approaches outlined in this concept paper.

The assessment, as outlined in the original scope of work, included the following objectives:

- Identify the status of HIV/AIDS prevention, care support, and treatment.
- Identify gaps and opportunities for program intervention**.**
- Identify strengths and weakness in implementation approach, for example policies, resources, and technology.
- Identify synergies with other donors.
- Identify synergies between USAID sectors.
- Identify linkages between national and community programs, between government and other sectors, and between nongovernment and private organization.
- Identify potential opportunities for scaling up successful interventions, while also identifying constraints and strategies to address them.
- Make recommendations for greater integration of programs and resources to support improved performance in addressing HIV/AIDS.
- Identify potential in-country key stakeholders to play a future role in guiding USAID implementation support.
- Identify potential stakeholders and technical expertise in the country and region to play a future role in strengthening programs.
- Plan scenarios, i.e., explore what program areas are best retained in instances of short funding or what program areas should be expanded or added in instances of increased funding.

COUNTRY CONTEXT (FROM EPI PROFILE)

The Co-operative Republic of Guyana, the only English-speaking country in South America, achieved independence from the United Kingdom in 1966 and became a republic in 1970.[1] It has a landmass of 215,000 square kilometers extending along the northeastern shore of South America[2] and is bordered by the Atlantic Ocean, Suriname, Brazil, and Venezuela. Guyana is considered part of the Caribbean region, a member of the Caribbean Community (CARICOM).[3] Guyana has a population of about 751,000 (UN Population Division, 2005)[4] of East Indian (43.5%), African/Black (30.2%), mixed (16.7%), and Amerindian (9.2%) descent.[5] More than 85% of the entire population lives along the coastal belt regions.

According to the 2002 census, the sex distribution of the population was 50.1% male and 49.9% female.[6] Approximately 35.5% of the population was under 15 and 7% over 60 years old.[7] Despite an abundance of natural resources, Guyana is one of the poorest countries in the Western Hemisphere. Guyana ranked 103 out of 177 countries in the United Nations Development Program (UNDP) Human Development Index (2006) and had an estimated GNI per capita of US$1,000 in 2005.[8] According to the latest Guyana Survey of Living Conditions, 36% of the population was living in absolute poverty (US$1.40/day).[9] Under the recent Multilateral Debt Relief Initiative, Guyana has qualified for an additional US$189 million after receiving debt relief totaling US$585 million in 2003 under the Enhanced Heavily-Indebted Poor Countries (HIPC) Initiative.[10]

As many as 78% of Guyanese households have electricity, and there is little difference in this indicator between urban (82%) and rural households (76%).[11] Interestingly, in Georgetown, 79% of households have electricity compared with 86% in other urban areas.[12] The majority of households cook inside the house using liquid petroleum gas or natural gas (50.9%), kerosene (37.9%), and firewood (8.8%).[13] The majority of households have access to clean water sources, while 24% rely on rainwater.[14] Before drinking it, 11.8% boil their water, 40% add chlorine or bleach, and 45.7% do not treat their water.[15] With regards to sanitation facilities, 43.3% use septic tanks, 30.2% use a pit latrine with slab, and 11.8% use a ventilated improved pit latrine.

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[1] UNICEF: *At a glance: Guyana: The big picture.* Accessed February 16, 2007, from http://www.unicef.org/infobycountry/guyana.html
[2] *Guyana UNGASS Report*: Reporting period, January 2003 – December 2005.
[3] *Guyana National HIV/AIDS Strategic Plan 2007–2011*.
[4] *Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Guyana*, 2006, WHO.
[5] *Guyana Population and Housing Census.* 2002. Accessed February 16, 2007, from http://www.statisticsguyana.gov.gy/pubs/CensusReport2002.pdf
[6] *Guyana National HIV/AIDS Strategic Plan 2007–2011.*
[7] *Guyana National HIV/AIDS Strategic Plan 2007–2011*.
[8] *The World Bank. Guyana Country Brief.* Accessed February 16, 2007, from http://Web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/GUYANAEXTN/0,,menuPK:32 8284~pagePK:141132~piPK:141107~theSitePK:328274,00.html
[9] *HIV/AIDS Indicator Survey*. 2005.
[10] The World Bank. *Guyana Country Brief.* Accessed February 16, 2007, from http://Web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/GUYANAEXTN/0,,menuPK:32 8284~pagePK:141132~piPK:141107~theSitePK:328274,00.html
[11] *HIV/AIDS Indicator Survey*. 2005.
[12] *HIV/AIDS Indicator Survey*. 2005.
[13] *HIV/AIDS Indicator Survey*. 2005.
[14] *HIV/AIDS Indicator Survey*. 2005.
[15] *HIV/AIDS Indicator Survey*. 2005.

According to the United Nations Children's Fund (UNICEF) demographic indicators for 2005, life expectancy at birth is 64 years and the infant mortality rate is 47 per 1,000 live births.[16] Acute respiratory infections, diarrhea, and accidents are the main causes of under-5 mortality (64/1,000 live births).[17] Guyana is dealing with emerging chronic, noncommunicable diseases (such as obesity), existing communicable diseases (tuberculosis [TB], malaria, Hansen's disease), HIV/AIDS, injuries, protein-energy malnutrition, and iron-deficiency anemia.[18] In 2000, HIV/AIDS was the leading cause of morbidity and the second highest cause of mortality.[19] Due to the increase in HIV/AIDS, TB (originally a problem of the Amerindian population in the interior) has spread to the coastal population.[20] The leading causes of noncommunicable disease mortality in adults are ischemic heart disease, cerebrovascular diseases, diabetes mellitus, accidents, and suicides.[21] Maternal mortality (170/100,000 live births) is also high due mainly to hemorrhages at pregnancy and childbirths, abortion-related conditions, and puerperium.[22]

HIV EPIDEMIC IN GUYANA

Guyana faces a low-level, generalized HIV epidemic. A cumulative 4,502 AIDS cases had been officially reported to the MOH by the end of 2004.[23] At that time, UNAIDS estimated that the prevalence of HIV infection among adults in Guyana was 2.5%.[24] UNAIDS estimates for Guyana suggest that at the end of 2005, there were about 12,000 adults and children currently living with HIV/AIDS and about 1,200 AIDS–attributable deaths. The age group mostly affected by HIV/AIDS (15–49) represents 51% of the population. Among certain groups, HIV prevalence is significantly higher due to behaviors associated with an increased risk of exposure.

A survey of 334 men who have sex with men was conducted in 2004.[25] Eighty participants (24%) agreed to provide blood samples, which were tested for HIV and syphilis. Among the participants who provided blood for serologic testing, 21% tested positive for HIV and 10% for syphilis. Nearly all of the men had heard of HIV; however, only 67% had ever heard of antiretroviral (ARV) therapy. The men tended to have multiple nonregular sex partners and commercial sex partners. Although 61% had a regular partner, even those assumed that their partner had other lovers, 83% had ever had sex with a woman, and 12% were currently married or living with a female. The risk behaviors in the population of men who have sex with men might affect levels of heterosexual transmission. Considering the high HIV prevalence and multiple sexual partners, men who have sex with men are at high risk for HIV in Guyana.[26] Like men who have sex with men, all female sex workers surveyed had heard of HIV, and 76% knew someone infected with or

[16] UNICEF. *At a Glance: Guyana.* Accessed March 26, 2007, from http://www.unicef.org/infobycountry/guyana_statistics.html
[17] *Country Cooperation Strategy at a Glance. Guyana.* PAHO. Accessed from http://www.paho.org/english/d/csu/BriefGUYEng.pdf
[18] *HIV/AIDS Service Provision Assessment Survey.* 2004.
[19] *Country Cooperation Strategy at a Glance. Guyana.* PAHO. Accessed from http://www.paho.org/english/d/csu/BriefGUYEng.pdf
[20] *Country Cooperation Strategy at a Glance. Guyana.* PAHO. Accessed from http://www.paho.org/english/d/csu/BriefGUYEng.pdf
[21] *Country Cooperation Strategy at a Glance. Guyana.* PAHO. Accessed from http://www.paho.org/english/d/csu/BriefGUYEng.pdf
[22] *Country Cooperation Strategy at a Glance. Guyana.* PAHO. Accessed from http://www.paho.org/english/d/csu/BriefGUYEng.pdf
[23] *2005 UNAIDS EPI FACT SHEET.*
[24] *Guyana UNGASS Report*: Reporting period – January 2003, December 2005.
[25] *Behavioral Surveillance Survey* (BSS+). Guyana Ministry of Health, 2004.
[26] *Behavioral Surveillance Survey* (BSS+). Guyana Ministry of Health, 2004.

dead as a result of HIV/AIDS. According to the latest seroprevalence survey among female sex workers in Guyana, HIV prevalence for this group is 27%. [27]

For youth aged 15–19 who are in school, 31% had ever had sex. This percentage is slightly higher in out-of-school youth. Males were more likely than females to report having sex in the 15–19 year age group in both in-school and out-of-school youth; however, this seemed to equalize for youth aged 20–24 years (84% of males and 74% of females).[28] In-school youth reported a median age at first sex of 15 years for both sexes. Out-of-school youth (15–19 years) reported a median age at first sex of 15 years for males and 16 years for females. Approximately one quarter (46/189) of the sexually active survey participants reported having sex in exchange for money or other material things in the last 12 months. This behavior was much less prevalent in out-of-school youths (3%). [29]

Gold and diamond miners were surveyed also. Guyana employs thousands of men in hundreds of mines in remote interior regions. Less than half (47%) were married or living maritally and 50% were migrant workers. Eighty-nine percent reported sexual activity in the last year, 50% reported having had sex with only one partner, and 15% had had sex with commercial sex partners. In 2004, HIV prevalence was 4% among miners, down from 7% in 2002. [30]

Among employees of the Guyana Sugar Corporation, approximately 96% of respondents were sexually active in the past 12 months. Of those, 86% reported sex with a regular partner, and only 2% of males reported they had more than one regular partner. Likewise, only 2% participated in commercial sex in the last 12 months. Among members of the uniformed services surveyed, 64% had correct knowledge about AIDS. Likewise, 63% had heard of medicines that people with AIDS could use to improve their health. Nearly all respondents were sexually experienced and 90% reported sexual activity in the past 12 months. Nearly half the respondents reported a regular partner in the past 12 months and 33% reported never being married. Although the median number of nonregular partners in the last 12 months was one (in a range of 0–35), 55% among the sexually active reported a nonregular partner in the past 12 months. Commercial sex was rare. [31]

TB is the most common opportunistic infection and the leading cause of death among people living with HIV/AIDS.[32] In high TB–burden settings, surveys have shown that up to 10% of HIV–positive persons might have previously undiagnosed TB at the time of receiving voluntary counseling and testing (VCT) and services for prevention of mother-to-child transmission (PMTCT), and up to half of these might be infectious TB cases.[33] Between 30% and 40% of people living with HIV/AIDS in these settings will develop TB in their lifetime, in the absence of preventive therapy or ARV therapy.[34] In an assessment of TB patients from 2005–2006, 79 of 253 TB patients (31%) reported knowing their HIV–infection status before starting TB treatment and were not retested for HIV. Of the 79 (84%), reported a positive HIV status. Of the remaining 174

[27] *Behavioral Surveillance Survey* (BSS+). Guyana Ministry of Health, 2004.
[28] *Behavioral Surveillance Survey* (BSS+). Guyana Ministry of Health, 2004.
[29] *Behavioral Surveillance Survey* (BSS+). Guyana Ministry of Health, 2004.
[30] *2006 HIV Epidemiological Profile, Guyana.*
[31] *Behavioral Surveillance Survey* (BSS+). Guyana ministry of Health, 2004.
[32] CDC. *Tuberculosis infection control in the era of expanding HIV care and treatment.* Accessed from http://www.cdc.gov/nchstp/od/gap/docs/InfectionControlAddendum_2-20-07.pdf
[33] CDC. *Tuberculosis infection control in the era of expanding HIV care and treatment.* Accessed from http://www.cdc.gov/nchstp/od/gap/docs/InfectionControlAddendum_2-20-07.pdf
[34] CDC. *Tuberculosis infection control in the era of expanding HIV care and treatment.* Accessed from http://www.cdc.gov/nchstp/od/gap/docs/InfectionControlAddendum_2-20-07.pdf

patients with unknown HIV status before diagnosis of TB, 73% were offered HIV counseling and testing, and 91% of those agreed to be tested.[35] Ten percent of those tested were HIV–positive. There is no agreed upon figure for TB/HIV coinfection among TB patients in Guyana; recent reports have estimated TB/HIV coinfection at 13%[36], 17%[37], and 20%[38].

Drug users constitute an important risk group for HIV in Guyana. In 2006, the Canadian Society for International Health (CSIH) conducted a study of the relationship between drug use behavior and HIV prevalence among 172 cocaine users in Georgetown during October and November 2006. Over half the participants (61%) reported a history of sexually transmitted infections and 18.2% had previously had TB. Of the 172 participants, 17% tested positive for HIV. Unprotected casual sex in the last six months occurred among 91% of the HIV–positive respondents and 66% of the HIV respondents. Seventy-nine percent of HIV–positive drug users already knew their HIV status before the study. Commercial sex workers (13%) were more likely to be HIV–positive.[39]

The 2005 Guyana AIDS Indicator Survey has shown that 98% of adults in the general population have heard of AIDS and that 76% of women and 81% of men know the two most important ways to avoid HIV transmission (i.e., using condoms and limiting sex to one uninfected partner). Nine percent of men and 1% of women reported having had more than one sexual partner in the last 12 months. Only about 1% of Guyanese men and women who have ever had sex reported having a sexually transmitted infection (STI) in the past 12 months. [40]

There have been few recent studies examining HIV prevalence among pregnant women in Guyana. In 1997, surveillance showed a 4% prevalence of HIV among pregnant women attending antenatal clinics in Georgetown. In 2004, antenatal clinic (ANC) surveillance was expanded to include more clinics across the country, and the adjusted HIV prevalence among ANC attendees was 2.3%. The age group with the highest prevalence (3%) was 35–39. In 2006, the adjusted HIV prevalence among ANC attendees was 1.5%, and the age group with the highest prevalence (3%) was 40–44. Prevalence among the urban population was 2.8% and rural was 1.1%. [41]

In 2006, 25,063 persons received VCT. However, even with the scaling up of VCT, only a small proportion of all respondents in all population groups reported knowing their HIV status. The number of persons receiving ARV therapy has increased from 123 in 2003 to 1,569 in 2006. The 2006–2010 HIV projections show 2.75% HIV prevalence in 2006. **The modeling suggests a slight upward trend in HIV prevalence, but a slight downward trend in HIV incidence.** As the prevalence increases, the needs for ARV therapy also increase, because people on ARV therapy are living longer. New AIDS cases are projected to stabilize out by 2010. If the PMTCT program continues in its current trajectory, the projections suggest a decrease in HIV–positive births from an estimated 24 in 2006 to six in 2010.[42]

[35] Guyana 05/06 MMWR, Surveillance Unit, 2006.
[36] WHO 2005 *TB Country profile for Guyana*
[37] *Guyana 2003 National TB Monitoring & Evaluation Plan*
[38] *Guyana 2004 National TB Programme Annual Report*
[39] *2006 HIV Epidemiological Profile, Guyana.*
[40] *HIV/AIDS Indicator Survey*. 2005.
[41] *2006 HIV Epidemiological Profile, Guyana.*
[42] *2006 HIV Epidemiological Profile, Guyana.*

II. Assessment Methodology

The assessment incorporated technical expert review of program documentation and qualitative data collection. The mission made 35 documents available to the assessment team. Documents included annual reports, work plans, national surveys, and epidemiological reports. HIV specialists from the assessment team reviewed all documentation. The program assessment team conducted semi-structured interviews with 46 stakeholders, which included international, government, and nongovernmental partners. The assessment team also conducted site visits to "hot spots," community-based organizations, and an urban clinic. Names of interviewees and sites will not be named in the report to honor confidentiality of participants.

III. Findings

CRITICAL ASSUMPTIONS

Critical assumptions have been made in the areas of financial resources, program partnerships, and epidemiological information. The conceptual framework was designed under the assumption that USAID and other U.S. Government (USG) agencies would provide annual support to Guyana that would maintain an average of $20 million. Another assumption is that the overall support levels currently provided by international donors would be sustained, in total allocated funds, but not necessarily in the same distribution. As USAID transfers the implementation of programs such as PMTCT to the Ministry of Health (MOH), it is essential that the Global Fund to fight AIDS, TB, and Malaria (GFATM) continue to provide funding to the Government of Guyana. It is important to note that financial support from the World Bank will end in 2008. World Bank supported critical programs implemented by NGOs and Line Ministries. New resources will need to be identified to continue these programs. It is assumed that the strong partnership between USAID and the Government of Guyana will continue and grow stronger. The conceptual framework below was developed in response to the current epidemiological and program information concerning the health status of the Guyanese people and the state of the HIV epidemic. If the information is inaccurate or more information becomes available, a revision of the framework should be strongly considered.

PEPFAR OVERVIEW

Critical strategic goals set by the USG that will contribute to the PEPFAR include (a) the *prevention* of 14,352 HIV/AIDS infections; (b) the provision of ARV *treatment* and related services to 1,800 persons; and (c) the provision of quality HIV/AIDS *care and support* service to 9,000 persons by 2008 in Guyana. Current achievements towards the 2008 goals for Guyana include (a) 1,500 persons received ARV treatment; (b) 10,000 women received HIV test results as part of the PMTCT Program; (c) an additional 20,000 men and women were tested for HIV; and (d) 1,900 persons received care and support services, including 900 orphans and vulnerable children (OVC).

Prevention services include (a) expanded access to PMTCT services, (b) community dialogue and action promoting HIV prevention, (c) reinforcing safer sexual behaviors, (d) reducing stigma, prevention for positives, (e) prevention in most-at-risk populations, (f) blood safety, and (g) safe medical injections. ARV treatment and related services include (a) expanded access to counseling and testing services, (b) expanded access to "PMTCT Plus" services, and (c) expanded access to ARV therapy and treatment for opportunistic infections (OIs). Care and support services include (a) enhanced capacity for a comprehensive, community-based response to needs of people living

with HIV/AIDS and (b) enhanced capacity for a comprehensive, community-based response to the needs of OVC.

Supportive interventions that foster achievement of the above USG Guyana strategic objectives in prevention, care and support, and treatment were carefully selected to build upon and complement the Government of Guyana's 2006–2010 National Strategic Plan (NSP) for HIV/AIDS and key goals of other major multilateral and bilateral donors. These goals include (a) advocating for bold leadership in government, in the private sector, among tomorrow's leaders, and among donor and multilateral partners; and (b) increasing the sustainability of HIV/AIDS program outcomes through targeted human capacity development, improved HIV/AIDS policy, multisectoral coordination and planning, enhanced capacity and quality of Government of Guyana HIV surveillance systems and data in decision making, increased capacity for advocacy around a comprehensive response to HIV/AIDS, and improved HIV/AIDS outcomes and programs through effective use of strategic information.

Two key, crosscutting goals will further contribute to the prevention, treatment, and care and support objectives of the PEPFAR strategy for Guyana. The first goal is to contribute to the Government of Guyana's strategy for an integrated, horizontal, health information system (HIS). This is a key component of the World Health Organization (WHO) goal of one monitoring and evaluation (M&E) system. The second goal is to improve capacity of the MOH Materials Management Unit (MMU) to ensure a steady supply of drugs, laboratory supplies, testing supplies, and other HIV/AIDS commodities through improvements to infrastructure, transport, information systems, and human resource capacity.

INTERNATIONAL DONOR SUPPORT

HIV/AIDS assistance from PEPFAR, the World Bank, and GFATM began at approximately the same time. All three programs cover expansive HIV/AIDS portfolios. Unfortunately, the World Bank and GFATM project funds are under-spent because the national absorptive capacity is nearly exhausted. World Bank support will end in 2008. In addition to PEPFAR, the World Bank, and GFATM assistance, the Inter-American Development Bank (IDB) and the UN are active in Guyana.

Although the IDB does not have HIV/AIDS–specific activities, it supports a health sector-strengthening project whose overall goals are to "Strengthen the institutional capacity of the health sector; improve the information and management system for the health sector; improve the procurement and distribution system for pharmaceutical and health materials. Develop the human resource working in the health sector, updating the curriculum and skills of doctors, nurses and allied health workers; review remuneration and allowances system to improve enrolment and retention in the health sector especially in the underserved areas. Improve the delivery system in the health sector, support integrated programs of primary and preventive health care interventions; upgrade equipments in regional hospitals and the in-patient ward of the Georgetown Public Hospital Corporation; rationalize the network of public health facilities; support the establishment of a national ambulance authority."[43] Collaboration between USAID and IDB should be actively explored.

[43] http://www.iadb.org/projects/Project.cfm?project=GY0077&Language=English

GOVERNMENT OF GUYANA NATIONAL AIDS PROGRAM ACHIEVEMENTS

The Presidential Commission on HIV produces an annual report on the status of the National HIV/AIDS Program. At the time of this report, the most recent data available was from 2004. However, the National AIDS Program recently published a report of the UN General Assembly Special Session (UNGASS) that highlights important national achievements. The table below outlines key indicators provided in the 2006–2007 UNGASS report.

Table 1. National AIDS Program Achievements 2007

UNGASS Related Indicator	Year	Value
Government funds allocated to the National AIDS Programme Secretariat	2007	US$503,805
Percent of donated blood units screened in public sector for HIV in a quality assured manner	2007	100.00%
Percent of adults and children with advanced HIV infection receiving ARV therapy	2007	60.25%
Percent of HIV positive women who received ARV therapy to reduce the risk of mother to child transmission	2007	63.50%
Percent of estimated HIV positive incident TB cases that received treatment for TB and HIV	2007	77.18%
Percent of persons aged 15–19 who received and HIV test in the last 12 months and know their results	2005	10.83%
Percent of adults and children with HIV known to be on treatment 12 months after initiation of ARV therapy	2006	74.5%

According to the 2006–2007 UNGASS Report, programmatic successes reported by the National AIDS Program Secretariat in the last two years were significant. The Guyana HIV treatment program was scaled up significantly to provide comprehensive care, treatment, and support for all people living with HIV. Since the establishment of free first-line treatment in 2002, the service had expanded to eight sites by the end of 2005. By the end of 2007, there were 14 treatment sites (including one mobile). Second-line treatment has been available to people living with HIV since 2006. As noted in Table 1, 60.25% of adults and children with advanced HIV infection received ARV therapy and 74.5% of adults and children with HIV are known to be on treatment 12 months after initiation of ARV therapy in 2007. Also noted above, 77.18% of estimated HIV incident TB cases received treatment for TB and HIV in 2007.

The home-based and palliative care program was launched in 2005. Persons receiving home-based care increased from 1,026 in 2006 to 1,223 in 2007. Guyana's first temporary, live-in care facility (with a capacity to accommodate 20 people living with HIV) was established in 2007 to provide palliative, end-of-life care and rehabilitative care. People living with HIV also receive training so that they can participate in income-generating ventures, and access to small loans is facilitated through the Institute for Private Enterprise Development (IPED). Support groups for people living with HIV were established at each treatment site.

The VCT program has expanded to improve access and ensure greater geographic coverage. The period under review saw an increase from 27 VCT sites (including one mobile site) in 2005, to 44 sites (including two mobile sites) in 2007. Eight of the 10 administrative regions now have fixed sites, and mobile teams deliver services to remote locations, thereby ensuring national coverage. As noted in Table 1, a national survey (the BBSS) reported that 10.83% of persons aged 15–19 years received a test in the last 12 months and knew their results. The national PMTCT program was expanded and strengthened, which resulted in PMTCT services being available at 110 facilities, an increase of 53 sites from 2005. Routine program data revealed a 97.8% acceptance rate among the 13,771 mothers offered testing. In 2006, 63.50% of HIV-infected women received ART to reduce the risk of mother to child transmission (Table 1). Finally, Table 1 illustrates that 100% of donated blood units are screened in the public sector for HIV in accordance with quality assurance standards.

The 2005 BBSS targeted most-at-risk populations, including sex workers, men who have sex with men, and others. The MOH is directing efforts at risk elimination and risk reduction for most-at-risk populations. Female sex workers and men who have sex with men are also being reached with a combination of targeted outreach and referrals and friendly clinical care and treatment services. This program is implemented in Regions 4 and 6 with plans for expansion into other regions.

The private sector partnership program developed in 2005 has evolved into a robust coalition of private sector organizations that are actively engaged in helping the Government of Guyana reach its goals of preventing and reducing HIV. Forty-three local private sector companies are currently collaborating with the program in an effort to protect the workforce against HIV and ensure the viability of private enterprise in Guyana.

Policy indicators show some room for improvement. Government funds allocated to the National AIDS Program Secretariat (NAPS) totaled US$503,805 in 2007 (Table 1) and the National Composite Policy Index was conducted in 2007; however, the results were not available for the 2006–2007 UNGASS report. Some progress has been made in the area of policy development. The first policy on HIV was approved by Parliament in 1998 and recent policy reform was concentrated in 2003–2006. The National Policy on HIV/AIDS was revised in 2003 to reflect changes within NAPS and to reflect a policy of universal access to treatment and care for all people living with HIV. Additional policy decisions, such as eliminating stigma or discrimination against those applying for social benefits and providing universal access to VCT and PMTCT, have also been integrated into the most recent revision of the national policy during 2006. A national blood policy was developed and presented to Cabinet for approval in 2006–2007. A draft OVC policy was prepared and presented to the Ministry of Labour, Human Services, and Social Security for approval. In 2006, draft HIV legislation was also developed and will be presented to Parliament during 2008. The draft legislation addresses a range of issues, including the protection of people living with HIV/AIDS from discrimination.[44]

[44] *2006/2007 UNGASS Report*, 2008.

USAID/GUYANA ACHIEVEMENTS

USAID has supported an HIV program in Guyana since 2002. PEPFAR support began in 2004. The indicators listed in Table 2 represent USAID–supported program results as of September 2007.

Table 2. USAID Achievements 2007

USAID Indicators	2007
Prevention of Mother to Child Transmission (PMTCT)	
Number of service outlets that provide the minimum package of PMTCT services according to national or international standards	45
Number of pregnant women provided with a complete course of ARV prophylaxis in a PMTCT setting	307
Number of health workers trained in the provision of PMTCT services according to national or international standards	275
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	22,378
Abstinence and be faithful programs (AB)	
Number of individuals reached through community outreach that promoted HIV/AIDS prevention through abstinence and/or being faithful	41,008
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (subset of AB)	25,083
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	446
Other prevention activities	
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	62,642
Number of individuals trained to promote HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	584
Number of targeted condom sales outlets	890
Palliative care: Basic health care and support	
Number of service outlets providing HIV–related palliative care (excluding TB/HIV)	10
Number of individuals provided with HIV–related palliative care (excluding TB/HIV)	1,032
Number of individuals trained to provide HIV–related palliative care (excluding TB/HIV)	171
Orphans and vulnerable children (OVC)	
Number of OVC served by OVC programs	903
Number of providers/caretakers trained in caring for OVC	120
Counseling and testing	
Number of service outlets providing counseling and testing according to national and international standards	26
Number of individuals who received counseling and testing for HIV and received their test results	43,768
Number of individuals trained in counseling and testing according to national or	172

Table 2. USAID Achievements 2007	
USAID Indicators	**2007**
international standards	
Strategic Information	
Number of individuals trained in strategic information	141
Other policy analysis and system strengthening	
Number of local organizations provided with technical assistance for HIV–related policy development	35
Number of local organizations provided with technical assistance for HIV–related institutional capacity building	32
Number of individuals trained in HIV–related policy development	80
Number of individuals trained in HIV–related institutional capacity building	315
Number of individuals trained in HIV–related community mobilization for prevention, care and/or treatment	100

Given the low, generalized epidemic with a high concentration of HIV in subpopulations, prevention was of great importance during the program period. It is projected that incidence in the general population will decrease, but prevalence will continue to rise over the next few years. USAID support to prevention programs was significant over the last five years and is outlined in the Table 2. The results are discussed below.

USAID supported 45 ANC and labor and delivery sites to provide PMTCT. At these 45 sites, 22,378 women learned their HIV status. Support groups for women and their families were established at NGOs and treatment sites as part of follow-up services for HIV-positive women. Community outreach programs promoted behavior change through one-to-one and small-group behavior-change interventions. A total of 41,008 people were reached with messages that promote abstinence and being faithful and 62,642 people were reached with messages that address behavior change beyond abstinence and being faithful. Through an innovative, condom social marketing program, 890 targeted condom outlets were supported. Finally, 1,305 people were trained in prevention-related activities.

Counseling and testing is a critical component to a comprehensive prevention, care, and treatment program. USAID supported 26 counseling and testing sites and 10 palliative care sites. A total of 43,768 people were tested and received their results. A total of 1,032 people infected or affected by HIV were provided with palliative care, not including care for a TB/HIV co-infection, and 903 children orphaned or made vulnerable by HIV were provided with care and support. It is important to note that other USG partners support ARV therapy programs and palliative care programs that include TB/HIV care. Finally, 463 people were trained in HIV testing, care, and support programs.

System strengthening, including policy development and strategic information are important supportive interventions for HIV programs. A total of 636 people were trained in systems strengthening, including strategic information. Thirty-five organizations have been provided with technical assistance in policy development. These organizations are mostly workplaces that participate in the part of the program that focuses on HIV in the workplace. Thirty-two organizations were provided with technical assistance in institutional strengthening. The majority

of these organizations are nongovernmental organizations (NGOs) implementing prevention, care, and support programs.[45]

In addition to the results provided in Table 2, USAID partnered with the Government of Guyana, local NGOs, and local private organizations to improve institutional capacity that has contributed to the sustainability of HIV programs in Guyana.

Successes in the area of prevention include enabling the Government of Guyana to achieve 80% coverage of PMTCT programs across the country, which reduces the projected number of infants born with HIV to as low as six by 2010. Stakeholders were asked, "What was the most successful USAID-supported program to date?" PMTCT was stated most often. Reasons for the success included relevance to the national program, national coverage, and the implementation of evidence-based programming. An example of evidence-based programming for PMTCT was the execution of a program evaluation assessing barriers to PMTCT services. [46] After the report was distributed to partners, USAID supported changes at the Labor and Delivery Unit and added community counselors to respond to loss-to-follow-up issues. Sustainability of the PMTCT Program was also well planned. Retired nurses were hired within the civil service scale, and most were transferred back into the civil service as USAID transferred the implementation of the PMTCT to the MOH in 2007.

Successes in the area of community outreach to promote behavior change include the large number of NGOs supported to implement structured behavior change interventions, and some progress was made to reach most-at-risk populations, especially female sex workers. Nontraditional condom outlets were supported by the condom social marketing program through private-sector partnerships. The cost effectiveness of the condom social marketing program in reaching places where high-risk behaviors occur is a possible success that should be evaluated further.

Successes in the counseling and testing program include important standard setting for the national program and expansion of services to the NGO community and a mobile unit. Technical assistance to the MOH enabled strong geographic coverage and good information systems. Other important successes to note are that rapid testing is offered in Guyana and links to services are facilitated by community counselors in some sites.

Home-based care and OVC services are important programs implemented primarily by the NGO community. Strong links between NGOs and clinical sites were described by stakeholders. Interviews with stakeholders also cited examples of links between NGOs and orphanages, workplaces, and schools. Community counselors and case navigator is a model used by both USAID and CDC to facilitate follow-up in times of rapid scaling up of services. This community counselor model might also be used to support the expansion of psychosocial and behavior change services. Stakeholders suggested an evaluation of the model.

The demand for strategic information and quality improvement appears to have been cultivated over the past five years. In addition, important national survey data supported by USAID has provided Guyana with baseline risk behavior and service coverage information. Private-sector partnerships, which for the most part are the workplace programs, were named as a best practice and identified as possible areas for expansion. Another best practice highlighted was the microfinance project, IPED.

[45] *Factors That Influence Women's Uptake of PMTCT Interventions in Georgetown, Guyana*, 2004.
[46] *Factors That Influence Women's Uptake of PMTCT Interventions in Georgetown, Guyana*, 2004.

The Supply Chain Management program supported by USAID is not highlighted in Table 2 and is relatively new to the USAID HIV portfolio. However, it constitutes close to 25% of the USAID annual budget. The program was cited as an early success, specifically in reference to relevance to the national program and prospects of sustainability due to strong partnerships with the government. Strong joint donor collaboration has also contributed of the success of the program. USAID assisted the MMU with organizational development milestones such as the adoption of a warehouse management information system and the design of a business plan that lays the foundation for the sustainability of management of HIV commodities for the MOH. [47]

Another program that is not reflected in Table 2 is the Community Support and Development Service Program (CSDS). This program was cited by stakeholders as neither a success nor a weakness; however, a technical review of the USAID HIV portfolio quickly reveals the promise of the CSDS and GHARP (the USAID flagship HIV project) partnership model. Implementation of community-based services such as community outreach to promote behavior change, home-based care services, and services for OVC require grants to NGOs working in HIV/AIDS. USAID supported technical assistance to NGOs in appropriate program areas through one institution and provided grants management and organizational development through a second institution. By 2006, a local accounting company was given the opportunity to manage NGO grants and provide organizational development services. Using a local firm is cost-effective and encourages sustainability. This model is a possible best practice.

Sustainability plans were implemented reviewed, and revised throughout the life of the programs and were strongly managed for the palliative care, counseling and testing, and workplace programs. However, SCMS and the PMTCT program were cited as the best examples of successful sustainability approaches used by USAID. This successful approach can be summarized in four tenants adhered to by the USAID HIV program: (a) the recognition that HIV infrastructure depends upon the health sector infrastructure, (b) stakeholder leadership and consultation, (c) the management of sustainable implementation as a crosscutting theme, (d) informal program management feedback loops at every level and in every technical area. The last point is reinforced by the observation that where the feedback loops were weak, sustainability of the program is weak.

USAID PROGRAM GAPS

Challenges for USAID support to the national program included implementing programs that addressed the highly concentrated nature of the low but generalized HIV epidemic in Guyana. HIV prevalence information was lacking, and support for HIV treatment was an exciting opportunity that had many important effects on community readiness to address HIV/AIDS on a national scale. However, the focus on clinical services necessitated that the civil-sector response and cutting-edge prevention programming went underdeveloped. The primary challenge or obstacle to reducing HIV in Guyana today was identified by interviewees as “changing behaviors.” Many respondents described awareness campaigns and quoted national survey results that illustrate that awareness and knowledge are high in Guyana. The next challenge is to effect individual risk perception and behavior change.

Prevention was named by almost all respondents as a critical gap in the national program. Substantial resources were dedicated to PMTCT, VCT, and youth outreach programs. Prevention services canvassed the country with nearly exhaustive coverage by 2007. Although 103,658 people were reached by community outreach designed to promote behavior change, it is not clear whether the correct people were reached with behavior change messages. As better prevalence

[47] *MMU Business Plan*, Ministry of Health Guyana, 2007.

information became available in 2005 and 2006, prevention programs should have been examined to assure that risk categories were appropriately proportioned. It appears that resources were not shifted from targeting the general populations (in school youth, GUYSUCO) and refocused on gathering better qualitative information on most-at-risk populations and designing extensive targeted interventions for various most-at-risk populations. Prevention for positives was underdeveloped throughout the life of the program. The condom social marketing program supported targeted condom outlets; however, they did not appear to be linked to the community outreach strategy. Finally, although USAID supported an injection safety project in Guyana through the Track 1 mechanism, national stakeholders generally identified both blood safety and injection safety interventions as CDC projects and were unfamiliar with the results of the program.

Care and support programs include counseling and testing, palliative care for adults, and programs for OVC. Counseling and testing services might have been better targeted to those who were most at risk. There was no evidence that links targeted prevention for most-at-risk groups and targeted counseling and testing supported by USAID. OVC and home-based care services are available in the most affected regions. Policies, standards, and sustainability strategies for OVC and home-based care programs in partnership with the government's National AIDS Program are areas that were weak.

Important areas for improvement or increased support identified by the literature and by stakeholders are quality improvement and systems strengthening. These areas were supported during the rapid scale-up, but can be strengthened in the next program period. Stakeholders recognized that human resources and workforce issues are much larger than the health sector or the HIV program. However, short and interim plans for human capacity development in this area can be addressed with sustainability as the long-term goal.

The NGO sector has strong roots in the community. The NGO response to HIV/AIDS emerged in the 1980s and 1990s, and continues to support community members today. The government has a short history of providing funds and technical assistance to the NGO sector. USAID has a long history of providing funds and technical assistance to the NGO sector. To support NGOs, a strong collaboration was established between USAID and the MOH Health Sector Development Unit, but it can be strengthened. The GHARP–CSDS partnership might provide some lessons learned to MOH.

Gender violence, psychosocial trauma, and effects of poverty on the individual were recurring themes in the stakeholder interviews and are issues that are currently addressed by the Ministry of Human Services. USAID also included services to address these issues within the care and support programs implemented by NGOs. However, it can be concluded that stakeholders agree that these services can be expanded or revised. Further investigation to determine how these issues affect HIV and can best be support through an HIV program might be important.

Possible constraints include the absorptive capacity of the Ministry of Health and the NGO sector. Another important constraint is the fact that the sustainability of HIV programs depends on health sector development. IDB is currently the only partner identified to work on health sector development. Human resources are an example of a constraint that reaches beyond the health sector. Finally, political will and community readiness to address stigma associated with HIV, death, sex work and transactional sex, men who have sex with men, and drug use are always challenges. Stigma and discrimination was the second most common obstacle to addressing HIV in Guyana noted by interviewees.

IV. Conceptual Framework

The proposed Guyana conceptual framework for 2009–2013 builds on past performance of USAID HIV programs and current gaps in the national HIV program. USAID played an important role in comprehensive HIV service delivery with a focus on the scaling up of public health care services. This included the provision of PMTCT services in antenatal clinics and labor and delivery units, and counseling and testing to both men and women at public health clinics. USAID also supported services provided by the civil and private sector such as workplace programs, behavior change programs, HIV awareness campaigns, condom social marketing, home-based care programs, and programs for OVC. In addition, USAID supported national survey data and program monitoring systems that were used to better target HIV prevention, care, and treatment programs.

After careful analysis of program data and the qualitative information provided by national stakeholders, USAID/Guyana will continue to implement activities under almost all 15 HIV program elements.

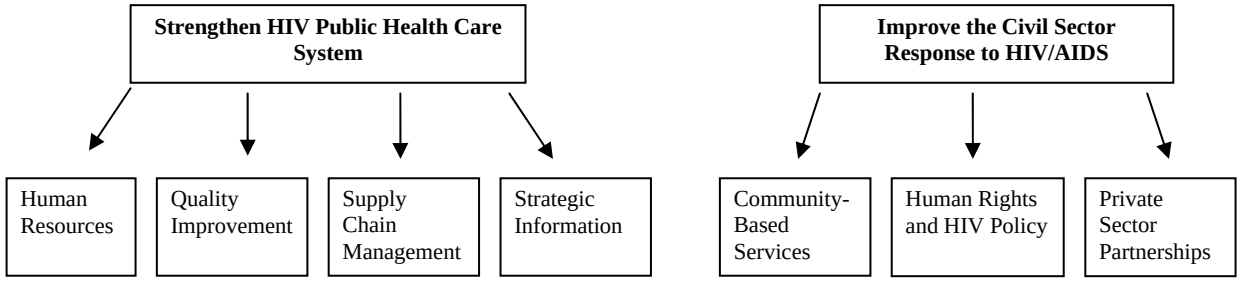

Figure 1. Guyana HIV Conceptual Framework 2009–2013

To build upon the successful scaling up and early sustainability achievements, USAID/Guyana will continue to support clinical services with a focus on the objective to "Strengthen the HIV Public Health Care System." To build upon the Mission's strong relationship with NGOs and the private sector, USAID will also focus on the objective, "Improve Civil Society Response to HIV/AIDS."

ASSISTANCE APPROACHES AND EXPECTED RESULTS

USAID will continue to support HIV prevention, care, and treatment programs implemented by the MOH with assistance from other government ministries, civil society, and the private sector. The USG played a strong role in the scaling up of PMTCT, counseling and testing, and palliative care. As the National AIDS Program matures and implementation is taken over by government health care and management personnel, USAID will continue to support these services. The foundations for strategic information, supply chain management, human resources, and quality improvement systems were established as HIV services were scaled up. At this time, geographic coverage is almost comprehensive, which provides the opportunity to focus on access, quality, and sustainability issues. As USAID supports the transfer of personnel and reduces support to direct implementation, support to system strengthening will increase. USAID will continue to support national-level coverage of HIV services. The focus on physical infrastructure, training new personnel, and baseline surveillance will shift to the development of a public health infrastructure that can independently support HIV surveillance and services. The SCMS project was cited as an early success because the MOH required the project personnel to work alongside

the MMU. To use this lesson, USAID will request similar direction as the mission designs projects to support MOH human resources, strategic information, and quality improvement. Technical assistance to the MOH will represent the majority of the resources that support the objective, "Strengthen HIV Public Health Care Services." USAID will continue to support the technical capacity of the National AIDS Program Secretariat; however, HIV public health care systems strengthening will require additional MOH partnerships. The early lessons provided by the SCMS Project show that USAID support to the overall MOH system can be achieved by developing an HIV-specific system, which is then used to inform the role out of the overall MOH system. Careful joint planning between the government and international donors working on health issues is a key to successful implementation.

The four interventions of human resources, quality improvement, SCMS, and strategic information are interrelated and should be managed holistically. As systems are strengthened, opportunities to improve access and quality of care will surface. Special attention to system design and strengthening should be given to pediatric AIDS, prevention for people who are HIV-positive, TB/HIV coinfection, and solutions for patients who are lost to follow up, such as the use of community counselors and navigators. It has been noted that the community counselors and navigators model might also be used to provide psychosocial support and prevention education.

These interventions are designed to strengthen the HIV public health care system to provide better prevention, care, and treatment with a trajectory of sustainability within the public sector. Human resource development will fall underneath the HIV program element, other/policy and system strengthening. Quality improvement will address all services with a focus on PMTCT and counseling and testing. The U.S. Centers for Disease Control and Prevention (CDC) should take the lead on ART services and quality improvement of palliative care. SCMS will correspond with the following HIV program elements: ARV drugs, counseling and testing, laboratory, other prevention, and injection safety. The strategic information intervention is one of the HIV program elements.

Support to human resource issues and the development of a human resource unit at the MOH is essential to building the infrastructure necessary to allow for the initial transfer and sustainability of HIV prevention, care, and treatment programs. Human resources of the MOH should be addressed at the central, regional, and outpost level. Human resource planning should be considered an ongoing and iterative process. USAID and other USG agencies have supported targeted strategies and pilot interventions designed to address specific human resource issues as needed. As part of the human resource intervention under the objective "Strengthen HIV Public Health Care Services," USAID will provide technical assistance for the development of a strategic plan for human resources. USAID will then look to the MOH to identify aspects of the plan that can be supported by the USG.

The human resources intervention must be driven by a Ministry of Health strategy. However, broad areas of technical assistance can be offered as the MOH addresses HIV human resource issues. Assistance with workforce planning can include national strategies and policies, but can also include advocacy and leadership programs for health sector development, human resource information systems and data use for decision making, and workforce realignment or task shifting. As the strategic plan is developed and implemented, workforce development and workforce performance will be addressed. Example of technical assistance that USAID might be able to provide include providing in-service training, especially highly relevant and advanced opportunities for HIV professionals, alignment of training curricula with national objectives, and strengthening professional associations and their programs for continuing education credits and certification. Other examples of technical assistance are improving supervision and quality assurance systems and initiatives to increase job satisfaction and retention.

These priority areas for human resource development were supported by stakeholders in Guyana. Guyanese healthcare professionals often reported pride in the quality of work as an incentive to remain in Guyana or remain with the Ministry of Health. Opportunities to apply creative problem solving and upward mobility in the work place can be provided by a quality improvement system that incorporates supportive supervision, but also must be supported by human resource policies and management. Skill-building was listed as an essential incentive that needs to be transparent and based on performance as well as seniority. The Caribbean HIV/AIDS Training Program offers HIV in-service trainings domestically and throughout the Caribbean. Other incentives to remain in the health care field in Guyana are mechanisms to facilitate affiliations with universities, private sector initiatives, and professional organizations that can further careers in HIV/AIDS. Possible affiliations should include national, Caribbean, and other international institutions. Opportunities to publish are also a way to increase job satisfaction among high-level professionals. Government incentives are also important; examples are duty free status and house lots.

Illustrative Indicators

- Percent of health care workers delivering HIV services that are employed by the MOH
- Number of people provided with advanced skill-building
- Percent of personnel working in HIV report job satisfaction
- Percent of HIV personnel that have an up-to-date professional development plan

Quality improvement mechanisms are in place in many of the HIV service delivery areas in Guyana. However, these mechanisms do not always address the service delivery area completely. In addition, most importantly, the mechanisms are not part of a quality assurance and improvement system that is integrated into the public health care system. The quality improvement intervention should be supported by both USAID and CDC. These agencies should act as co-supporters to the MOH. USAID and CDC will request direction from the MOH to identify the correct partners within the MOH. For the HIV quality improvement system to be implemented, the MOH must establish a strategy to integrate the system into overall management at the national, regional, and outpost level. Therefore, the Disease Control Unit will likely be a primary partner. The role of regional offices should be closely examined during the design of the quality improvement system. The design of a comprehensive HIV quality improvement system will necessitate strong leadership from the National AIDS Program Secretariat in reference to HIV standards and program improvement. NGOs deliver a great proportion of the services supporting the national HIV program and provide important links to clinical services as well. The systems to improve quality at NGO level should be considered at the onset of the system design.

Quality improvement systems are important at every level of service delivery and program management. Quality improvement can affect every aspect of service delivery from many different perspectives. As the system is designed, several “dimensions of quality” should be taken into consideration. Technical performance is the degree to which the tasks carried out by health workers and facilities meet expectations of technical quality (i.e., adhere to standards). Access to services is the degree to which healthcare services are unrestricted by geographic, economic, social, organizational, or linguistic barriers. Effectiveness of care is the degree to which desired results (outcomes) of care are achieved. Efficiency of service delivery is the ratio of the outputs of services to the associated costs of producing those services. Interpersonal relationships include the components of trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening, and communication between providers and clients. Continuity of services is achieved when the client receives care by the same healthcare provider throughout the course of care

(when appropriate) and appropriate and timely referral. Safety is the degree to which the risks of injury, infection, or other harmful side effect are minimized. Physical infrastructure and comfort is very important and includes the physical appearance of the facility, cleanliness, comfort, and privacy. Finally, choice, as appropriate and feasible, is an invaluable way to facilitate efficiency, adherence to health promotion plans and treatment, and clear communication between client and provider.

Desired key outcomes from a quality improvement system noted by stakeholders included surveillance information, especially drug resistance information and providing quality services as an employment incentive for health care providers to remain in the public health care system. These findings support the concept that systems strengthening to the public health infrastructure are considered essential and interdependent. A holistic approach to systems strengthening should be the goal, while also focusing on key activities that can be measured at the end of a program period.

USAID should support overall system design, but with an emphasis on PMTCT, counseling and testing, home-based and palliative care, OVC, and safe injection. CDC should also support the overall system design with an emphasis on ART delivery and palliative care, especially pediatric AIDS and TB/HIV coinfection. Quality improvement for laboratory services should be lead by the CDC.

Illustrative Indicators

- Percent of clinical sites with standards of HIV care available at the site
- Percent of personnel providing a service that has been trained in that service in the last 12 months
- Percent of personnel reporting accepting attitudes towards people living with HIV/AIDS

Comprehensive support to the development of SCMS began in 2007. The MOH provided strong leadership at the very beginning of the program and directed USAID to work closely with the MMU. Other donor support allowed USAID to fund the selected components of the system, while also providing key technical assistance to the MMU such as strategic planning and system design. USAID will continue to support SCMS as an intervention under the objective, “Strengthen HIV Public Health Care.” As stated earlier, all four interventions are interrelated and USAID should use lessons learned from the progress made in this area to ensure successful scaling up in remaining program interventions.

An MMU business plan was drafted in November of 2007. The document provides a strong vision, but also allows for flexibility as the MMU and the MOH gain operational experience that will inform future direction. The MOH envisions that the MMU will become a center of excellence for all aspects of supply chain management. Strategic objectives to achieve this goal are to maximize operational efficiency and to optimize supply chain resources. As the MOH realizes this goal, the MMU will be able to ensure consistently the timely acquisition, storage, and distribution of essential medicines of good quality, in optimal quantities against the lowest possible costs. The strategic objectives to achieve this standard of performance are to build MMU capacity, creating viable, sustainable systems, to support rational use of drugs and healthcare supplies, and to lead an integrated procurement process.

The MOH has identified types of technical assistance that USAID will provide to assist the MMU in achieving excellence. At first, the MMU will require technical assistance such as warehouse management support and on-the-job training; training development and delivery; information

technology; forecasting, reporting, and procurement support; infrastructure design, costing, and construction. As this early phase comes to a close, USAID will no longer support physical infrastructure and system design, but will continue to provide technical assistance and training on issues that emerge as the system matures and the MMU becomes less dependent on donor support.

USAID is currently supporting ARV drugs, counseling and testing supplies, and laboratory supplies. USAID should continue to support these areas in addition to adding other prevention materials (condoms to clinics and NGOs), and safe injection supplies.

Illustrative Indicators

- Number of people trained in supply chain management
- Percent accuracy of stock by quantity, number, and location
- Percent accuracy of orders placed to suppliers
- Percent MOH procurements managed by the MMU

Strategic information is a means for quality improvement, public health surveillance, and program management; therefore, the design of a strategic information system cannot be isolated from NAPS. However, a parallel information system is not advised; therefore, most of the surveillance, statistical analysis, and evaluation technical assistance should be provided to a central MOH unit that is mandated to work with the NAPS. In this concept paper, we will refer to such a unit as a Management Information System (MIS) Unit. Clear lines of communication and clear scopes of work for personnel in the MIS Unit and the NAPS can create transparent mechanisms for collaboration within the MOH. Routine data should flow up from the clinic-based or community-based organization to the regional unit or NAPS to the MIS Unit. Cohort studies, program evaluations, and quality improvement reports should be implemented by the NAPS. Periodic survey and special study data can flow down. Studies can be managed by the MIS Unit while enlisting collaboration from the NAPS on study design and programmatic conclusions. The MIS Unit can serve the NAPS by providing standard setting, study design, annual program monitoring and surveillance reports, and statistical analysis to enable data use for program planning, evaluation, and quality improvement.

It is important to remember that strategic information and the systems that provide the information are a means to an end. Therefore, the approach to implementing the strategic information intervention is to place the concept of data use for decision making as central to all system design and all supporting activities. The system design must differentiate between routine information and periodic surveys, while always holding data use for decision making as central. For example, the capacity to collect, analyze, and use data should be focused on site managers, program managers, and technical advisors. The majority of the technical assistance resources should be provided to these individuals. An M&E unit to process information is essential to the system, but should not be the focus. As the system design addresses periodic data collection and analysis (e.g., national surveys or program evaluations), requesting assistance from and presenting information to mangers and technical advisors will already be in place at each level—if the routine strategic information system is functioning successfully.

Program monitoring systems are currently in place for clinical services. Limited program monitoring is in place for community-based services such as prevention, home-based care, and programs for OVC. As the community-based services intervention matures, so will the program monitoring system to support these systems. A critical component of the monitoring system for community-based services is the establishment of a social networking model and the detailed monitoring system that will be required to track the social networks and the periodic review of

this information. Community-based programs will expand and contract as the information becomes available.

Important baseline surveys have been completed in Guyana. A national-level survey to determine risk behaviors and access to services for the general population was completed during the previous HIV program. Behavioral surveillance surveys (BSS) provided some insight on the characteristics and risk behaviors of several subpopulations. A national survey of health clinics in Guyana also provided important baseline information about service coverage and quality.

A Demographic and Health Survey (DHS) in Guyana is planned. This survey will provide important health statistics that will better enable stakeholders to understand the HIV epidemic in Guyana. Annual ANC and PMTCT surveys must be supported in the future. An HIV prevalence component of the DHS would provide invaluable understanding of the state of HIV in Guyana. USAID has supported the Government of Guyana in the completion of a broad list of BSS for high-risk groups. In the future planning of behavioral surveillance, USAID will focus on those populations that are at the *most* risk. Previous BSS information will allow program managers to prioritize which surveys are necessary.

Program evaluations should be identified through the life of the program. However, the program assessment exercise completed for the development of this concept paper identified several important areas for consideration. First, a comprehensive program evaluation of the PMTCT program should be completed. Important aspects of the program to be examined are sustainability solutions, cost-effectiveness strategies, community and health worker sensitization to HIV services, and quality improvement issues during rapid scaling up, including an analysis of the community counselor and case navigator model as a possible best practice. Second, cost-effectiveness studies on the Community Support Development Service Project and the condom social marketing program. Third, evaluate the HIV patient cohort data to investigate the emergence of possible drug resistance. Fourth, conduct an environmental scan to establish push and pull factors specific to Guyana that will inform a comprehensive national human resource strategy. Fifth, provide needs assessments for improving pediatric AIDS and prevention-for-positives services. Finally, map high-risk behaviors to identify geographic hotspots and new subpopulations or niches within the current subpopulations that can be explored further. Qualitative studies should be designed to provide more in-depth knowledge that can launch prevention interventions that have been identified as a critical gap in the national program. These qualitative studies can also improve BSS activities so that the national program can track change over time.

Illustrative Indicators

- Number of site and program managers trained in M&E
- Number of special studies completed

- Number of M&E staff trained in statistical analysis and database skills
- Number of workshops held to develop study conclusions or program improvement

The previous USAID HIV program provided strong support to the public sector, while also providing strong support to the civil sector. Strong public-private sector partnerships were fostered by USAID and then leveraged to support services implemented by the NGO sector. NGOs were directly supported by USAID to implement HIV services, while also ensuring that NGOs had access to technical guidance and organizational development assistance. Stigma and discrimination policy activities were also part of the previous program. USAID will build on strong relationships with the NGO sector and the private sector to support the objective, "Improve the Civil Sector Response to HIV/AIDS."

The community-based services intervention will be the backbone intervention for this objective. USAID will support integrated prevention, care, and treatment services through NGOs. USAID will work closely with the MOH to coordinate USAID supported NGOs, MOH-supported NGOs, and links to clinical services at public health care sites. USAID will request to work closely with the MOH to design technical assistance and organizational development strategies for NGOs that support the national strategy and improve MOH support to the NGO sector. USAID will build upon the current strengths of the NGO sector, which include counseling and testing, home-based care, and programs for OVC. USAID will improve the quality of these activities while also introducing a new strategy for community outreach and prevention services. The social network model will enable NGOs to reach more people at most risk for HIV, while also aiming to bridge the gap between those that identify as part of a high-risk population and those that might be better reached by a general population intervention, but are engaging in risky behavior.

To support the objective "Improve the Civil Sector Response to HIV/AIDS," community leadership and advocacy for HIV issues and HIV-related human rights are of paramount importance. USAID will support programs designed to meet the prevention, care, and treatment needs of civil society while also creating an enabling environment for emerging leaders to come forward. The human rights and HIV policy intervention will work with emerging leaders, while also collaborating with the Government of Guyana, NGOs, and the private sector to draft policies and legislation that support human rights, discourage discrimination and improve HIV services. The private-sector partnership intervention will support the human rights and HIV policy intervention and the community-based services intervention with programs such as HIV in the workplace, condom social marketing, and other activities that encourage a multisectoral response. Gender violence, psychological trauma, and poverty issues were crosscutting themes that were noted by national stakeholders as barriers to accessing quality HIV services. These issues will be addressed throughout the HIV program, but can be directly addressed under this objective.

Interventions designed to support the objective, "Improve the Civil Sector Response to HIV/AIDS," include community-based services, human rights and HIV policy, and private-sector partnerships. Community-based services will include AB (abstinence and being faithful) prevention, other prevention, counseling and testing, home-based and palliative care, and OVC. Human rights and HIV policy is an important supportive intervention that falls underneath the HIV program element, Other Policy Analysis and System Strengthening. Private-sector partnerships can be developed in any of the HIV program elements. However, workplace programs and condom social marketing are successful interventions in the previous HIV program and should benefit from private-sector partnerships leveraged by USAID. These programs, for example, fall underneath AB prevention, other prevention, and counseling and testing.

The community-based services intervention will be implemented as a seamless network model project. The intervention will directly deliver HIV prevention, care, and support services to populations at most risk for HIV, while simultaneously promoting sustainable, evidence-based community services. The intervention will build on earlier successes in the NGO sector to address individual risk perception, promote individual behavior change to prevent HIV transmission, and increase individual health seeking behaviors (testing, care, treatment) through peer-to-peer interventions.

Significant resources were used to support workplace programs, faith-based organization activities, school-based activities, and community-based activities for youth. The previous HIV program also supported HIV behavior change interventions delivered to men who have sex with men, sex workers, and people living with HIV/AIDS and their families. The outreach approach for those most at risk was limited to places that are "well known" sites where individuals meet new partners, sell sex, and/or engage in other high-risk behaviors.

The limited depth of program and surveillance information leads USAID/Guyana in an important new direction. The community-based services intervention will emphasize the need to document the social networking behaviors of the people reached and expand outreach services to places where current high-risk clients and their partners can be accessed. This means that outreach cannot be limited to self-identified people who sell sex and/or engage in male-to-male sex. Outreach cannot be limited to bars, strip clubs, and informal gatherings established as safe places for highly stigmatized behavior to occur.

Community-based services should build upon previous interventions designed to reach most-at-risk clients and those designed to reach the general population. This can be accomplished by carefully monitoring the geographic mapping of places where people meet new sex partners and engage in high-risk behaviors. As the social networking model saturates those places where high-risk behavior occurs, the program will simultaneously target the outreach strategy to sites that are identified as places closely associated with documented network members, but that are not necessarily "well known" sites where risk behavior occurs. For example, churches or workplaces in geographical hotspots might be identified as venues where persons who do not want to be identified as men who have sex with men, sex workers, or people living with HIV/AIDS but who are engaged in high-risk behaviors (such as multiple concurrent partnerships or transactional sex) can be reached with interventions. Different outreach approaches and behavior change interventions will need to be tailored for these venues in the same way that such interventions are tailored for identified sex workers or gay men. General mass media can be deemphasized as specialized information, education, and communication and behavior change communication are expanded.

As the intervention is expected to build upon the social networks that have been identified in the previous program, it will also be expected to expand the types of services made available to communities at risk. Community-based HIV testing, community care and support, and support to OVC are important services that are currently available, but should be seamlessly linked with the peer-to-peer behavior change interventions that address individual risk perception, individual behavior change to prevent HIV transmission, and individual health seeking behaviors (testing, care, treatment). Although community-based testing makes HIV testing generally more accessible to everyone, it is especially important for people engaging in risky behaviors. People most-at-risk for HIV often fear or experience discrimination from members of the established health care system resulting from stigma associated with the risky behaviors. Counseling and testing is a necessary bridge to care and treatment services available through the public health care system as well as through community-based organizations in Guyana. However, these services are not always sensitive to the needs of marginalized populations. The community-based services

intervention will continue to provide care and support and counseling and testing, while also designing mechanisms to decrease stigma and discrimination towards high-risk populations at community-based and public health care service delivery sites. Activities to decrease stigma and discrimination as a barrier to care should be closely linked to the quality improvement intervention, under the objective, "Strengthen HIV Public Health Care Systems."

Technical assistance to build local capacity for the strategic planning, implementation, and monitoring of community HIV services within local governments, NGOs, and community- and faith-based organizations will be a priority. Onward granting to NGOs, community- and faith-based organizations is a sustainability strategy that should be expanded. Organizational development and technical expertise are of equal importance for the development of the civil sector's response to HIV/AIDS. USAID will build on successes in the previous program by continuing to provide both organizational development and technical expertise. USAID should also incorporate a mechanism to share this successful model with the Ministry of Health. Currently, the MOH provides small grants to community-based organizations. Some organizational development opportunities are available from the MOH; however, its technical expertise is not strategically offered to the community-based organizations. USAID can offer technical assistance to the MOH in this area.

Illustrative Indicators

- Number of people reached with one-to-one behavior change interventions designed to promote prevention beyond abstinence and being faithful, disaggregated by target populations and by intervention session
- Number of people reached with "one off" small group interventions, disaggregated by target population and prevention message
- Number of people reached by multisession HIV education and awareness interventions, disaggregated by target population and prevention message
- Number of people referred to health care services, disaggregated by target population and type of service
- Number of new one-to-one clients that report perceived risk for HIV
- Number of existing one-to-one clients that report perceived risk of HIV
- Number of new one-to-one clients that report engaging in high-risk behaviors
- Number of existing one-to-one clients that report engaging in high-risk behavior
- Number of new one-to-one clients that report condom use at last sex act
- Number of existing one-to-one clients that report condom use at last sex act
- Number of existing one-to-one clients known to access referral services, disaggregated by target population and type of service
- Number of people counseled and tested and received their results, disaggregated by target population
- Number of people provided with home-based care services

- Number OVC provided with care and support
- Number of organizations provided with technical assistance in institutional strengthening

USAID will support the human rights and HIV policy intervention with specific strategies that can be measured at the end of the program period. Public-private sector alliances around specific issues and policy instruments can play an important role in this intervention. Cross-sector partnerships within the USAID program are also an important resource to consider. USAID supports a good governance program that provides technical assistance on policy development and drafting legislation. USAID will closely examine opportunities for its democracy and governance program to support human rights and HIV policy.

Although there are a number of policy-related activities to support stigma and discrimination, a comprehensive HIV policy strategy is not in place. USAID, the Government of Guyana, and private and nongovernment partners should jointly set policy goals to reduce stigma and discrimination and improve human rights in relationship to HIV. The 2006–2007 UNGASS Report outlines policy reform achievements to date. USAID will support future policy reform through technical assistance. Some specific instruments or policy actions that were identified as in need of support include formal approval of a national HIV/AIDS policy, workplace policy, legislation on sexual abuse, the "Children's Bill" (which includes the OVC policy), and the cancellation of the value-added tax on condoms. These activities will include a targeted information dissemination strategy to decision makers and the public. Private-sector leveraging, identified as a success or best practice by USAID and other donor agencies, could be continued as part of the policy activity.

Passing legislation and putting policy into place is a very important step in reducing stigma and discrimination, and in improving human rights. However, this intervention will not affect HIV programs and society unless community leadership at the individual and grassroots level is fostered, developed, and brought to the forefront. A small community leadership program that is integrally linked with the community-based services intervention can identify "Champions for Change" in Guyana. Through the peer outreach and NGO development components of the community-based services intervention, leaders will emerge. The human rights and HIV policy intervention can provide training and mentorship to those that are interested in advocacy and national planning issues. Developing mechanisms for these emerging leaders to engage in program planning and policymaking will be a key component of the over all policy strategy.

Illustrative Indictors

- Number of leaders trained
- Number of people living with HIV/AIDS and most-at-risk populations on planning committees
- Number of policies drafted

The private-sector partnership ntervention will build upon a strong coalition of 43 private sector organizations. These organizations have worked with the Government of Guyana to reduce the impact of HIV on society. Workplace programs implemented in partnership with the U.S. Department of Labor (USDOL), International Labour Organization (ILO), and Ministry of Labour was a successful intervention for demand and coverage. Forty-three organizations have developed workplace policies and workplace programs for HIV/AIDS. A microgrants program has produced successful support to people living with HIV/AIDS.

To date, USAID has played a large role in implementing workplace programs. Workplace programs will be a very important component in the new program period. However, USAID should step down support to a technical assistance role. The USDOL/ILO and Ministry of Labour should work with USAID to set priorities, make new private-sector partnerships, and link the workplace program with the community-based services intervention. Many links between the NGO and private sectors have been established through the workplace program. An important area for expansion is the link between the workplace and the prevention and behavior change component of the community-based services intervention. The vision for the social networking model to saturate high-risk populations and link to populations that do not necessarily identify as high-risk hinges on USAID's ability to link interventions like workplace or faith-based programs to prevention activities implemented by NGOs.

Microgrants and microloans for people infected and affected by HIV were provided under the IPED Program. USAID should continue to support this program with technical assistance. An evaluation of the program can identify opportunities for expansion. Possible opportunities for cross-sector programming within USAID (economic development program), should be explored. Educational grants for people infected and affected by HIV will be considered once more information on the current program is available.

Another important example of private-sector partnerships that has yielded success and should be continued is the condom social marketing program. It improves access to condoms through nontraditional outlets by expanding the number of sales points of existing commercial brands. The program is innovative and appropriate for Guyana and has established good working relationships with the importers. The condom social marketing program has contributed to increased access by geographic extension and type of outlet. Ultimately, the sustainability of this extended distribution network will depend upon demand creation leading to increased stock rotation at the sales points; and forging direct links between the importers and national distributors and the intermediate regional distributors and sales points.

Demand creation for condom social marketing is currently implemented by the MOH in coordination with the generic condom promotion. USAID should play a role in the further coordination between MOH, the condom social marketing program, NGO implementation (especially as community-based services expand) to ensure that condom distribution sites are optimally placed. As NGOs gather data, condom social marketing sites should be mapped on top of behaviors and sites (both NGO and clinical). Conversely, behaviors and service information should be provided to the condom social marketing program.

Illustrative Indicators

- Number of organizations proved with technical assistance in policy development
- Number of targeted condom outlets

ROLE OF USG AGENCIES

Roles in responsibilities for each USG agency will remain the same overall. CDC and USAID have many opportunities for collaboration. Most notable are quality improvement and strategic information. USDOL should take the lead on workplace programs, but with technical assistance from USAID.

Table 3. Select Indicators and Preliminary Targets for USAID HIV Program 2009 and 2013		
USAID Indicators	**2009**	**2013**
Prevention of mother-to-child transmission (PMTCT)		
Number of service outlets that provide the minimum package of PMTCT services according to national or international standards	45	110
Number of health workers trained in the provision of PMTCT services according to national or international standards	275	500
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	12,000	12,000
Abstinence and be faithful programs		
Number of individuals reached through community outreach that promoted HIV/AIDS prevention through abstinence and/or being faithful	10,000	15,000
Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	30	50
Other prevention activities		
Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	20,000	35,000
Number of individuals trained to promote HIV/AIDS prevention through other behaviour change beyond abstinence and/or being faithful	200	300
Number of targeted condom sales outlets	900	1500
Palliative care: Basic health care and support		
Number of service outlets providing HIV–related palliative care (excluding TB/HIV)	14	14
Number of individuals provided with HIV–related palliative care (excluding TB/HIV)	1,200	1,800
Number of individuals trained to provide HIV–related palliative care (excluding TB/HIV)	100	120
Orphans and vulnerable children (OVC)		
Number of OVC served by OVC programs	1200	1800
Counseling and testing		
Number of service outlets providing counseling and testing according to national and international standards	26	44
Number of individuals who received counseling and testing for HIV and received their test results	15,000	35,000
Number of individuals trained in counseling and testing according to national or international standards	120	220
Strategic Information		
Number of individuals trained in strategic information	100	155

Table 3. Select Indicators and Preliminary Targets for USAID HIV Program 2009 and 2013		
USAID Indicators	**2009**	**2013**
Other policy analysis and system strengthening		
Number of local organizations provided with technical assistance for HIV–related policy development	35	45
Number of local organizations provided with technical assistance for HIV–related institutional capacity building	35	35
Number of individuals trained in HIV–related policy development	50	100
Number of individuals trained in HIV–related institutional capacity building	120	120
Number of individuals trained in HIV–related community mobilization for prevention, care and/or treatment	200	300

BUDGET SCENARIOS

The conceptual framework is designed for an annual budget of $10-15 million. The illustrative annual budget outlined below in Table 4 provides the details of a $12 million budget for the first year. The budget lists the conceptual framework interventions distributed across the PEPFAR program elements.

US$12 Million Budget

The budget in Table 4 shows a $12 million annual budget. It is important to note that resources for supply chain management should decrease over the five-year period, while human resources and quality improvement might increase. Resources for community-based services, human rights and HIV policy, and private-sector partnerships may be distributed differently within the intervention, but should remain relatively the same across the interventions. Preliminary targets outlined in Table 3 correspond with the annual budget in Table 4.

US$10 Million Budget

If the budget for the USAID program were reduced to $10 million, quality improvement, strategic information, and human resources would be severely affected. Human rights and HIV policy could also be reduced. Budgets for community-based services and private-sector partnerships should remain the same. USAID should also aggressively seek other donor support for supply chain management (especially procurement of commodities) to reduce the budget for that intervention. Preliminary targets in Table 3 would be revised. Examples of reduction in results include the number of PMTCT, palliative care, and counseling and testing sites supported by USAID. Quality improvement, strategic information, and human resource systems would be less extensive and less developed overtime. Human rights and HIV policy would be reduced to an emerging leadership program only. An overall reduction in budget would jeopardize the security of commodities, including ARV drugs.

US$15 Million Budget

If USAID is able to secure a $15 million budget under the new conceptual framework, community-based services and human rights and HIV policy interventions should be expanded in scope and technology. Community-based services should continue to map risk behaviors with prevention, care, and treatment services, including targeted condom outlets supported by the

private sector. The community-based services intervention can expand geographically with additional resources, including cross-border programs. More importantly, additional resources would be used to improve the specificity of the targeted information, education, and communication materials and to increase stigma and discrimination interventions designed to reduce barriers to counseling and testing, care, and treatment. A cutting-edge mass media campaign to reduce stigma and discrimination could support the community-based services intervention and the HIV policy and legislation activities planned under the conceptual framework. This type of media campaign is not planned underneath the $12 million budget. Such a campaign must be designed to support quality (targeted services provided by clinical sites and NGOs) while supportive policy and legislation is drafted. A stigma and discrimination campaign must also include an evaluation component to be effective.

Table 4. Illustrative Annual Budget for USAID HIV Program 2009–2013											
		Human Resources	**Quality Improvement**	**Supply Chain**	**Strategic Info**	**Public Sector Total**	**Community-Based Services**	**HIV Policy**	**Private Sector**	**Civil Sector Total**	**USAID Total**
Prevention	PMTCT	$0	$300,000	$0	$0	$300,000	$0	$0	$0	$0	**$300,000**
	Abstinence/Be Faithful	$0	$0	$0	$0	$0	$600,000	$0	$50,000	$650,000	$650,000
	Injection Safety	$0	$100,000	$100,000	$0	$200,000	$0	$0	$0	$0	$200,000
	Other Prevention	$0	$0	$100,000	$0	$100,000	$2,100,000	$0	$100,000	$2,200,000	$2,300,000
	Sexual Prevention Subtotal	*$0*	*$0*	*$100,000*	*$0*	*$100,000*	*$2,700,000*	*$0*	*$150,000*	*$2,850,000*	*$2,950,000*
	Subtotal	***$0***	***$400,000***	***$200,000***	***$0***	***$600,000***	***$2,700,000***	***$0***	***$150,000***	***$2,850,000***	*$3,450,000*
Care	Palliative Care: Basic health care and support	$0	$200,000	$0	$0	$200,000	$600,000	$0	$100,000	**$900,000**	$1,100,000
	OVC	$0	$100,000	$0	$0	$100,000	$600,000	$0	$50,000	**$850,000**	$950,000
	Counseling and Testing	$0	$300,000	$300,000	$0	$600,000	$1,200,000	$0	$100,000	**$1,400,000**	$2,000,000
	Subtotal	***$0***	***$600,000***	***$300,000***	***$0***	***$900,000***	***$2,400,000***	***$0***	***$250,000***	***$2,650,000***	***$3,550,000***
Treatment	Treatment: ARV Drugs	$0	$0	$2,200,000	$0	$2,200,000	$0	$0	$0	$0	$2,200,000
	Pediatric AIDS	*$0*	*$0*	*$200,000*	*$0*	*$200,000*	*$0*	*$0*	*$0*	*$0*	*$200,000*
	Laboratory Infrastructure	$0	$0	$100,000	$0	$100,000	$0	$0	$0	$0	$100,000
	Subtotal	***$0***	***$0***	***$2,500,000***	***$0***	***$2,500,000***	***$0***	***$0***	*$0*	***$0***	***$2,500,000***
Other	Strategic Information	$0	$0	$0	$1,000,000	$1,000,000	$0	$0	$0	$0	**$1,000,000**

Table 4. Illustrative Annual Budget for USAID HIV Program 2009–2013											
		Human Resources	**Quality Improvement**	**Supply Chain**	**Strategic Info**	**Public Sector Total**	**Community-Based Services**	**HIV Policy**	**Private Sector**	**Civil Sector Total**	**USAID Total**
	Other/policy analysis and system strengthening	$1,000,000	$0	$0	$0	$1,000,000	$0	$500,000	$100,000	$600,000	**$1,600,000**
	Subtotal	***$1,000,000***	***$0***	***$0***	***$1,000,000***	***$2,000,000***	***$0***	***$400,000***	***$100,000***	***$600,000***	***$2,600,000***
TOTAL		**$1,000,000**	**$1,000,000**	**$3,000,000**	**$1,000,000**	**$6,000,000**	**$5,100,000**	**$400,000**	**$500,000**	**$6,000,000**	**$12,000,000**

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